STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E376	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH, LLC	305 E NORTH ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: September 24, 25, 26, 27, 28, and October 1, 2012 Facility number: 000450 Provider number: 15E376 AIM number: 100273890 Survey team: Diane Hancock, RN, TC Amy Wininger, RN Barbara Fowler, RN Vickie Ellis, RN Census bed type: NF: 39 Total: 39 Census payor type: Medicaid: 31 Other: 8 Total: 39 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 4, 2012 by Bev Faulkner, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review and interview, the facility failed to ensure the privacy curtains were closed during provision of care for 2 of 39 residents reviewed for privacy. (Residents #26, #5) Findings include:	F0164	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction	10/22/2012

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	1. An observation was made on 9/26/12 at 3:30 p.m., of Resident #26 during repositioning and incontinence care. CNA [Certified Nurse Aid] #3 was observed removing the resident's sheets and saturated incontinence pads with the curtain between the roommates a third of the way pulled; leaving the resident exposed to his roommate's view. An observation was made of Resident #26 on 9/27/12 at 8:45 a.m., of the resident's legs and his position. During this time, CNA #4 pulled the sheets back exposing the resident's lower half in which the resident had no clothing except socks on the lower part of his body. The curtain between the resident and his roommate was not pulled; leaving the resident exposed to the roommate's view.		be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F164 It is the practice of TranscendentHealthcare to assure that residents are treated in a dignified manner includingthe provision of privacy during care.** ***The correction actiontaken for those residents found to be affected by the deficient practiceinclude:*** Residents #5and #26 receive personal care services in a manner that enhances privacy. ***Other residents thathave the potential to be affected have been identified by:*** Potentiallyall residents could be affected. Pleasesee below for measures implemented to prevent reoccurrence. ***The measures orsystematic changes that have been put into place to ensure that the deficientpractice does not recur include:*** Reinforcement of the facility policy related to privacy will occur with the nursing staff. The nursing staff has been in-serviced related to assuring	

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	2. On 9/28/12 at 10:50 a.m., CNA #1 was observed in Resident #5's room. Resident #5 was observed to be up in a mechanical lift sling and being transferred back to bed after a shower. The resident was loosely covered with towels, but was not fully covered. The resident's room-mate was in bed, and the room-mate's family member was in the room within		that privacy is provided during personal care. The in-service will specifically address the proper pulling of the privacy curtain. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents for provision of privacy during personal care. This tool will specifically observe for the pulling of the privacy curtain.. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 22,2012	

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	view of the resident. The privacy curtain was partially pulled, but the resident, while up in the sling, was out away from the privacy curtain. After the resident was transferred to bed, she was uncovered, dried off, and dressed. The privacy curtain was not pulled sufficiently to provide privacy as the room-mate's family member was in view of the resident. 3. The Director of Nurses [DoN] provided a Quality of Life-Dignity policy and procedure, dated 2001 and revised 2010, on 10/1/12 at 8:50 a.m. The policy included, but was not limited to, the following: "Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms. b. Curtains will be pulled when providing care..." "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures..." 3.1-3(p)(4)			

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F0318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion received treatment and services to maintain the range of motion or prevent further decrease in range of motion, for 1 of 3 sampled residents reviewed for range of motion in a sample of 8 who met the criteria, in that the resident was discontinued from physical therapy and the functional maintenance program did not include complete range of motion exercises. (Resident #13) Finding includes: On 9/25/12 at 9:43 a.m., RN #1 was interviewed. She indicated Resident #13 did not have any contractures. On 9/25/12 at 11:45 a.m., Resident #13 was observed to be in bed with her knees drawn up near her chest. On 9-26-12 at 10:09 a.m., CNA #1	F0318	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F318 It is the practice of TranscendentHealthcare to assure that residents identified with limited range of motionreceive services to increase range of motion and/or prevent further decrease inrange of motion.** ***The correction actiontaken for those residents found to be affected by the deficient***	10/22/2012

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	was observed giving a bed bath to Resident #13. After the bed bath, CNA #1 and the Restorative CNA transferred the resident from bed to the wheelchair. The CNAs used a gait belt, but ended up lifting the resident from under her thighs and arms. The resident did not bear any weight. The resident's knees did not straighten out. Throughout the observation, no range of motion exercises were provided. Resident #13's clinical record was reviewed on 9/26/12 at 10:00 a.m. The resident was admitted to the facility on 6/1/12, with diagnoses including, but not limited to, dementia, peripheral vascular disease, history of deep vein thrombosis, history of colon cancer, and hypertension. The resident's Admission Minimum Data Set [MDS] assessment, dated 6/13/12, indicated the resident had limitations in range of motion on both sides. The Quarterly MDS, dated 8/27/12, indicated the same limitations on both sides. The record indicated the resident was discharged from Physical Therapy on 7/12/12. The discharge status indicated the following: Hip extension and abduction range of		***practiceinclude:*** Resident #13has been re-assessed and receives proper range of motion services based on theassessment. ***Other residents thathave the potential to be affected have been identified by:*** All residents have had range of motion assessments completed. Any resident identified to have limited range of motion will receive the necessary services to assist with the prevention of further decline. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** When therapy services discontinue therapy, therapy will communicate with nursing to identify what types of services, including range of motion, are needed for the resident through the restorative program. Based on therapy recommendations, the programming, including range of motion (if applicable) will be initiated. Through a combination of Therapy and Nursing, residents will be screened for range of motion on a quarterly basis. If a resident is shown to have a decline in range of motion, an appropriate program will be established. The nursing staff has been in-serviced related to the importance of providing range of motion in correlation with the plan of care. ***The corrective action taken to monitor***	

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	motion limited both sides Knee extension limited both sides Discharge note: "Will discharge from PT and place on restorative care. When she receives her brace, PT will pick her back up to monitor brace and skin integrity to prevent further contractures." The record indicated Occupational Therapy [OT] was continuing to see the resident for upper extremity range of motion, since 8/15/12. A Functional Maintenance Plan, dated 7/3/12, "to help prevent further decline in ROM [range of motion]..." was part of the care plan. It indicated the resident was to have bilateral upper and lower extremities range of motion 20 repetitions daily. On 9/27/12 at 10:45 a.m., the Restorative CNA was interviewed. She indicated she did not provide any services to the resident currently. The Certified Occupational Therapy Assistant [COTA] was interviewed on 9/27/12 at 11:20 a.m. He indicated Occupational Therapy was seeing the resident for shoulder pain and upper extremity range of motion. On 9/28/12 at 10:45 a.m., the Director		***performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents for range of motion assessment and proper provision of services. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** 10-22-12	

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	of Nurses [DoN] was interviewed. She indicated everyone was on a Functional Maintenance Program and the CNAs were to do the range of motion. She retrieved the documentation for the ROM. This resident had ROM documented every day but 9/26/12. CNA #1 was interviewed on 9/28/12 at 11:00 a.m. She indicated she had provided range of motion exercises during the bath on 9/26/12. She indicated, "they told us it counted when we moved them around getting dressed." She indicated she didn't do a specific number of repetitions, just moved their arms and legs while getting them dressed. The Range of Motion Policy (no date) was provided by the DoN on 10/1/12 at 8:50 a.m. The policy included, but was not limited to, the following: "It is the policy of [name of facility] to assure that residents receive services to assist with the prevention of contractures via the use of range of motion if indicated as necessary based on the assessment." "Services, if indicated, will be established and provided through physical/occupational therapies, restorative nursing, or through a functional nursing maintenance			

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	program..." "Actual Range of Motion Procedure: Position resident in good body alignment Support limb above and below joint Joints that may be included in range of motion are: Neck, Shoulders, Elbows, Wrist, Thumbs, Fingers, Hips, Knees, Ankles, and toes. Slowly and gently move joints in all directions it would normally move Repeat movement of joints at least 5 times Encourage resident to participate as much as possible..." 3.1-42(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident received supervision and appropriate assistance with a transfer, for 1 of 6 residents observed during transfers, in that a resident was transferred with a lift into a wheelchair while the wheelchair was not locked and the sling/lift positioned in a way that the cross bar nearly hit the resident in the face as it was repositioned during and after the transfer. (Resident #34) Findings include: An observation of Resident #34 was made on 9/26/12 at 11:45 a.m. CNA #2 and LPN #1 were observed to be placing Resident #34 into her wheelchair using a mechanical lift. A sling was placed under Resident #34 and attached to the lift. The resident was lifted with the lift and transferred to the side of her wheelchair. The resident was placed over the side of her wheelchair by CNA #2 and LPN #1 with one lift leg positioned	F0323	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F323** **It is the practice of this facilityto assure that the all residents reside in an environment that remains free ofaccident hazards as is possible.** ***The correction actiontaken for those residents found to be***	10/22/2012

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	between the front and rear wheels and the other lift leg behind the back wheels. Resident #34 was lowered into her wheelchair. While lowering the resident into the wheelchair, the wheelchair tilted back on its rear wheels with CNA #1 standing behind it. The wheels were not locked on the wheelchair. LPN #1 lowered the lift and the crossbar was observed to be close to the resident's face. CNA #2 was observed to have her hand across Resident #34's chin so the crossbar would not come into contact with the resident's face. After removing the sling handles from the crossbar, LPN #1 elevated the crossbar while CNA #2 moved her hand up to the resident's nose for protection. Interview with the DoN [Director of Nursing] on 9/27/12 at 3:45 p.m., indicated it was dangerous to the resident to have the resident transferred to her wheelchair in this manner. The "Owner's Operator and Maintenance Manual" for the mechanical lift indicated the wheelchair wheel locks must be in a locked position before lowering the resident into the wheelchair to prevent movement of the chair during		***affected by the deficient practiceinclude:*** Resident #34is now being transferred appropriately in accordance with the manufacturer'sguidelines. ***Other residents thathave the potential to be affected have been identified by:*** . Allresidents that utilize a Hoyer lift for transfers are being moved in a mannerthat is in accordance with the manufacturer's guidelines.. ***The measures orsystematic changes that have been put into place to ensure that the deficientpractice does not recur include:*** Nursing hasbeen in-serviced related transferring residents properly utilizing the HoyerLift. The in-service includes locking ofthe wheelchair during transfers and assuring that the resident is in no dangerof being hit by the cross-bar of the Hoyer. ***The corrective***	

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	transfer to a wheelchair. 3.1-45(a)(2)		***actiontaken to monitor performance to assure compliance through quality assurance is:*** A PI toolhas been established that observes up to 5 Hoyer Lift transfers to assure thatthey are done safely and in accordance with the manufacturer's guidelines. The Director of Nursing, or designee, isresponsible for completion of the tool. This tool will be completed weekly x3, monthly x3, then quarterly x3. The quality assurance committee will reviewthe PI tools at the regularly scheduled meetings with additionalrecommendations if there is any negative outcome on the PI tools. ***The date the systemicchanges will be completed:*** October 22,2012	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure recipes were followed in the preparation of pureed food for 1 of 1 meal (noon meal), which had the potential to affect 13 of 13 residents who received pureed foods. (Resident #34, Resident #14, Resident #15, Resident # 19, Resident # 18, Resident # 35, Resident # 25, Resident #26, Resident # 4, Resident #7, Resident #9, Resident #20, Resident #30) Findings include: Cook #1 was observed on 9/26/12 at 11:15 a.m., to be preparing to puree the main entree for the noon meal of spaghetti with meat sauce. The recipes were for 15 servings. Cook #1 was observed to obtain 15 scoops of prepared spaghetti using a #8 scoop and placed it into the blender. She added 3 cups of tomato juice and 7 and 1/2 slices of white bread into the blender. When interviewed regarding	F0363	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F363 It is the practice of Transcendent Healthcare of Boonville North to prepare meals in accordance with the menus.** ***The correction action taken for those residents found to be affected bythe deficient practice include:*** Residents #34, #14, #15, #18, #19, #35, #25, #26, #4, #7,#9, #20, and #30 are receiving	10/22/2012

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	using the prepared spaghetti, Cook #1 indicated she used the spaghetti they had prepared for all of the residents usually. The recipe for puree spaghetti with meat sauce indicated a 1/2 cup of meat sauce and a 1/2 cup of spaghetti for each serving were to be combined with the 3 cups of tomato juice. Then 7 and 1/2 ounces of wheat bread were to be chopped in a food processor and blended with 1/2 of the hot liquid. The remaining liquid was to be added gradually for mashed potato consistency. The spaghetti was to be garnished with 1 cup of parmesan cheese, divided into 15 servings sprinkled over the entree, when served. Dietary Aide #1 indicated the parmesan cheese had already been added to the prepared spaghetti prior to her pureeing the food. Cook #1 was observed on 9/26/12 at 11:45 a.m., preparing to puree the menued noon meal which included green beans. Cook #1 was observed to obtain 15 scoops using a #8 scoop of cooked green beans, which she placed into the food processor. Cook #1 added 7 1/2 slices of white bread and 7 1/2 tsp margarine.		their pureed diets in accordance with the recipes. ***Other residents that have the potential to be affected have been identified by:*** All pureed diets were identified in the survey findings. All menus have been reviewed to assure that recipes are being followed per the regulations. Please see systematic changes below to prevent re occurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All dietary staff has been in-serviced related to following of the menus and recipes when preparing pureed food. The menus are established with correlating recipes as approved by the Registered Dietitian. The Dietary Manager will be responsible for assuring that the appropriate products are in place to assure that the recipes can be followed. See below for monitoring to assure recipes are being followed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 meals to verify the menus and recipes were followed related to the puree diets. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly	

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	The recipe for pureed green beans included 15 scoops of cooked green beans using a #8 scoop, 7 1/2 sliced of wheat bread and 7 1/2 tsp of margarine. Interview with the Dietary Manager on 9/26/12 at 11:25 a.m., indicated she had checked the recipes on 9/25/12 and thought they requested white bread and she had not ordered any wheat bread. Cook #1 was observed on 9/26/12 at 11:30 a.m., preparing to puree the menued noon meal which included tossed salad. Cook #1 was observed to place a bowl of pre-measured lettuce, 7 1/2 slices of white bread, 1/2 cup salad dressing, and 1 cup mashed potato flakes into the blender. No green peppers or celery were added to the mixture. The recipe for 15 servings using a #20 scoop included "1 1/2 each" of iceberg lettuce, 1 cup of fresh green peppers, 1 cup diced celery, 7 1/2 slices each of wheat bread, 1/2 cup salad dressing, and 1 cup instant potato flakes. The serving utensil used was a #20 scoop. The recipe indicated the cook was to chop and blend the lettuce, add the green peppers and celery and blend, The		x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed if needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 22, 2012	

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	bread pieces were to be added and blended and the salad dressing was to be added in 3 additions. The dressing was to be blended after each addition. The mashed potato flakes were to be added if the product was not mashed potato consistency. Interview with Cook #1 on 9/26/12 at 11:35 a.m., indicated there were no green peppers or celery available to place in the salad, but she had added 1 1/2 cups of shredded cheese to the lettuce before pureeing. Interview with the Dietary Manager on 9/26/12 at 11 40 a.m., indicated she did not have wheat bread as she thought the recipe had requested white bread. She indicated she did not have green peppers or celery available either. 3.1-20(i)(4)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure foods were stored and utensils were sanitized properly for 1 of 1 kitchen. This had the potential to affect 39 of 39 residents in the facility who received food from the kitchen. Findings include: During initial tour of the kitchen on 9/24/12 at 9:45 a.m., the dishwasher was observed being utilized. The wash temperature obtained a reading of 148 degrees and the rinse cycle obtaining a reading of 180 degrees. Documentation throughout the month of September, 2012, included temperatures ranging between 141 - 150 degrees for the wash cycle and 177 - 183 for the rinse cycle with no documentation noted for September 1, September 2, September 5 - 11, September 15 - 16, and September 22 - 24. The Administrator was notified of the inaccurate temperature of the dishwasher.	F0371	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F371** **It is the practice ofthis facility to assure that foods are stored and utensils sanitized properlyin accordance with facility policy.** ***The correction action taken for those residents found to be affected bythe deficient practice include:*** No specificresidents were	10/22/2012

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	The "Recording of Dish Machine Temperatures" policy obtained on 9/24/12 from the Administration, indicated any inaccurate temperatures must be brought to the attention of the Dietary Manager immediately. The policy indicated the entries for the dishwasher are to be made daily. The expected temperatures for the heat sanitized dishwasher would be: 150 degrees for the wash cycle and for the rinse cycle 180 degrees. During initial tour on 9/24/12 at 9:45 a.m., no thermometers were found in the kitchen refrigerator and the #2 upright freezer. Blueberry muffin mix was observed opened in a sealed bag with no date on it. Tortilla chips, which were opened with no date, were observed on the shelf in the dry storage area. Pasta noodles were observed in large storage containers with no date on them. Interview with Cook #1 on 9/24/12 at 10:00 a.m., indicated the dishwasher temperature is to be documented everyday and all opened items are to have the date they were opened. Interview with the Dietary Manager on		identified. Thedishwasher is now running at appropriate temperatures. All food items are now dated appropriately inaccordance with facility policy. Thereis now a thermometer present in the kitchen refrigerator and each of thefreezers. ***Other residents that have the potential to be affected have beenidentified by:*** Potentiallyall residents could be effected. Becauseof the corrections that have been implemented, the dishwasher is operating andsanitizing appropriately, and opened containers are now dated properly.Refrigerator and Freezer temperatures are being monitored properly. ***The measures or systematic changes that have been put into place toensure that the deficient practice does not recur include:*** The dietarystaff has been in-serviced to reiterate the proper temperatures needed for thedish machine to provide acceptable sanitation as well as the importance ofassuring that opened containers are dated and	

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	9/24/12 qt 10:10 a.m., indicated the temperature is to be documented everyday when the dishwasher is operated. The Dietary Manager indicated dry items are to be sealed after they are opened and labeled with the date they are opened they are opened with the date and they are to be opened. Interview with the Dietary Manager on 9/28/12 at 2:00 p.m., indicated the dry items are to have a date on them and the refrigerators and freezers are to have thermometers in them. 3.1-21(i)(3)		stored properly. The in-service also included assuring themonitoring of the temperatures in the kitchen refrigerator and freezers. Please refer to monitoring systems to assurecompliance dishwasher sanitization and food storage. ***The corrective action taken to monitor performance to assure compliancethrough quality assurance is:*** A PerformanceImprovement tool has been established that randomly reviews dishwashertemperatures and observes for storage of food properly. The tool also looks at the temperature log ofthe kitchen refrigerator and freezers. The Dietary Manager, or designee, willcomplete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediatelyaddressed. The Quality AssuranceCommittee will review the tool at the scheduled meeting following thecompletion of the tool with recommendations as needed based on the outcomes ofthe tool. ***The date the systemic changes will be completed:*** 10-22-12	

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	By submitting the enclosed material we are not admitting the	10/22/2012

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	ensure the infection control program was implemented to prevent potential transmission of infection, for 7 of 12 residents observed receiving care, and for 1 of 1 randomly observed resident, in that gloves were not changed and hands washed after handling soiled items and/or catheter care was done in a manner to potentially cause infection. (Residents #33, #2, #9, #5, #34, #13, #18, #22) Findings include: 1. On 9/28/12 at 10:16 a.m., an observation of CNA [Certified Nurse Aide] #4 providing incontinence care to Resident #33 was made. Upon entry to the room, feces was noted on the resident's floor. CNA #4 removed some toilet paper from the bathroom and wiped up the feces off the floor, bare handed with the toilet paper and put it in the toilet bowl. She then put gloves on her hands without washing her hands and proceeded to give Resident #33 a bed bath and incontinence care. She turned the resident to her left side and wiped the resident's buttocks with a wash cloth. The wash cloth was visibly soiled with stool. CNA #4 then rinsed the wash cloth out in a bucket of soapy water and washed the anal area again,		truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective October 22, 2012 to the annual licensure survey conducted on September 24, 2012 through October 1, 2012. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need for review. **F441 It is the practice of Transcendent Healthcare of Boonville North to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident#33, #9, #2, #5, #34, #13, #18, and #22 are receiving services in a manner that is in accordance with infection control guidelines. This includes incontinence care, catheter care, personal grooming, and medication pass. ***Other residents thathave the potential to be affected have been identified by:*** All residents could potentially be affected. All residents are receiving services in	

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	using the same wash cloth. She then proceeded to wash the resident's labia area using the same wash cloth she used for the buttocks. The CNA washed the cloth out in the soapy water and proceeded to wash the resident's legs. During the care, the CNA was observed using a total of two wash cloths, one for washing and one for drying.		a manner which promotes acceptable infection control. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Anin-service has been conducted for nursing staff related to proper infectioncontrol practices. The in-service addressesproper hand washing, proper changing of gloves, and proper cleaning techniquefor incontinence care and catheters. The facility will be randomly observingstaff that is providing services to assure that proper infection controlprotocol is followed in accordance with the facility policy ***The corrective actiontaken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 residents related to following of proper infection control procedures during the provision of services. The observations include incontinence care, catheter care, and medication pass. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations	

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	2. During the medication pass observation on 09/25/12 at 12:00 p.m., RN #1 was observed to enter the room of Resident #2. At that time, Resident #9 was observed to be lying in bed with her dentures hanging from her mouth. RN #1 was observed to apply gloves and remove dentures from Resident #9, and place the dentures in a cup. At that time, RN #1 was observed to not perform hand hygiene before applying a new set of gloves and administering eye drops to Resident #2. 3. During an observation of a shower on 09/28/12 at 10:36 a.m., Resident #5 was observed to be sitting in a shower chair on a Hoyer sling. At that time, CNA #1 indicated she would perform catheter care for Resident #5. CNA #1 was then observed to pull slightly on the catheter tubing, wash the peri-area of Resident #5 with a quick back and forth motion and rinse the area with water from the handheld shower. During an interview on 09/28/12 at 10:45 a.m., CNA #1 stated when catheter care was provided in the shower she "just		for new interventions as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 22,2012	

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	pulled it out a little and washed it with water." CNA #1 further indicated it was much easier to perform catheter care when the resident was in bed. The policy and procedure for Perineal Care provided by the DoN [Director of Nursing] on 09/28/12 at 11:54 a.m., indicated, "Steps in the Procedure...9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary			

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	movement of the catheter.)" 4. During observation on 9/26/12 at 11:45 a.m., CNA #2 and LPN #1 were observed placing a mechanical lift sling under Resident #34. CNA #2 and LPN #1 assisted the resident into her wheelchair and CNA #2 combed the resident's hair. LPN #1 took Resident #34 out of the room. CNA #2 and LPN #1 did not wear gloves while assisting Resident #34. LPN #1 washed her hands in the bathroom in the hall. CNA #2 applied gloves and proceeded to Resident #22's bed. Resident #22 indicated she was finished using the bedpan and CNA #2 removed it from under the resident. CNA #2 wiped Resident #22 with wet washcloths and discovered the resident was having an incontinent bowel movement. After Resident #22 was finished having her bowel movement, CNA #2 obtained clean, wet washcloths from the MDS [Minimum Data Set] Coordinator and proceeded to wiped Resident #22 clean. After wiping the resident, CNA #2 removed her gloves and washed her hands. 5. On 9-26-12 at 10:09 a.m., CNA #1 was observed giving Resident #13 a bath. The resident had been incontinent of urine and a small amount of feces. The CNA cleansed			

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	the resident's peri-area of the urine and feces. She continued to wear the same gloves to dry the resident's skin, handle clean clothes, place a clean incontinence brief on the resident, and put a skin barrier lotion on the resident. She then did change one glove and put lotion on the resident's arms and legs and hands. She then dressed the resident. CNA #1 then gathered the soiled linens, took her gloves off and then went to the clean utility room and washed her hands. 6. On 9/26/12 at 11:45 a.m., CNA #1, LPN #2, and the COTA were observed to transfer Resident #18 from a chair to the bed using a mechanical lift. The resident was checked for incontinence. He had been incontinent of urine and had smears of feces. CNA #1 and CNA #2 cleaned the resident. The same gloves were worn to clean the urine and feces from the skin, and then handle a clean towel, clothes, and covers. Both CNAs then gathered the linens, removed the gloves, took the bagged soiled linens to the soiled utility room and went across the hall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E376	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	to the clean utility room to wash their hands. **The policy and procedure for Infection Control [no date] was provided by the Director of Nurses on 10/1/12 at 8:50 a.m. The policy and procedure included, but was not limited to, the following: "Use good hand washing techniques. Hand washing is the best way to prevent the spread of infection." "Practice medical asepsis--keep clean away from dirty, handle linen properly..." "Use standard precautions." "Standard Precautions are guidelines developed by the Center for Disease Control [CDC] to reduce the risk of transmission of pathogens from both known and unknown sources of infection in a health care setting. Every person is treated as potentially infectious. Sources of infection include: blood, all body fluids, secretions and excretions (except sweat) regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes. Standard Precautions include: a. Wearing gloves when indicated for resident care... c. Washing your hands at appropriate times..."			

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	"Consider all blood, body fluids and excrement contaminated." The Handwashing/Hand Hygiene policy and procedure, dated 2001 and revised 2010, was provided by the DoN on 10/1/12 at 8:50 a.m. The policy included, but was not limited to, the following: "When to wash hands...After contact with a resident's mucous membranes and body fluids or excretions." 3.1-18(l)			